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Planning Social Hygiene: From Contamination to Contagion in Interwar India

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Introduction

The interwar period (1918–39) was one of rapid sociopolitical change in colonial India. It saw the emergence of mass-movement anti-colonialism, communal nationalism, and a thoroughgoing women's movement, as well as the scalar reorganization of the state through the systems of dyarchy (partial provincial self-government) and fuller regional autonomy through the Government of India Acts (1919 and 1939). Inflected by all these changes, but possessing a logic that was both its own and linked to broader international shifts, were trends in medicine and public health. These trends can be framed in various narratives: the shift from curative to preventative medicine; the movement from a colonial enclavist concern for the elite to a more nationalist concern with the broader population; or the diffusion of scientific spatial organization from medical institutions to the broader public sphere. These are questions of racial sociology, geography, and anthropology, but running throughout them all is a shift in the scientific episteme from that of contamination to that of contagion. This shift had been ongoing since the late nineteenth century, but in the interwar period it was refracted through the logic, and 'art of government,' of hygiene. This emphasis had effects not just on parasitological understanding and pathogenic theories, but also on the planning of cities and the way in which international campaigners focused their social reform efforts in India. This chapter will open with some reflections on contagion theory and urban planning, and will then move on to consider the emergence of hygiene theory and its effects on colonial biopolitics. It will demonstrate this shift through, first, an analysis of changing public health policies in Delhi, including those regarding venereal diseases and prostitution, and second, a study of international

campaigns against venereal diseases. These two examples will provide valuable case material, but will also shed light on broader processes due to their wider significance. Delhi became the capital of colonial India in 1911, and the transformations that took place there clearly show how urban planning was dependent upon the whims of colonial governors in this period. The regulation of prostitution, as Foucault famously argued, comes at the intersection of individual self-conduct and the regulation of the population.¹ Referencing concerns over 'racial' decline, birth rates, family life, fidelity, and imperial sexuality, the prostitute stands at the nexus of individual morality and demographic anxiety. In the interwar period, internationalist campaigning against sexual contagion, here studied via the British Social Hygiene Council's work, marked a transformatory shift in Indian public health policy. In surveying these developments, this chapter will hopefully encourage contemplation of the 'late colonial' period during which India continued to act as an epistemic, as well as military and economic, sub-imperial pole for the Indian Ocean arena.²

Contagion, Hygiene, and Colonial Biopolitics

In his classic work *Colonizing the Body*, David Arnold made it clear how intensely geographical Indian colonial medicine was.³ One of these geographies was spatial and concrete: the institutions (the hospital, jail, and barracks) that allowed intense observation, and control, of disease. These spaces of colonial modernity allowed an aesthetic, a limited practice, and a boundless fantasy of control to spread through the imperial imagination (see, for instance, the images of King George's Hospital at Lucknow, opened in 1911, and the Mayo Hospital at Lahore, opened in 1871, included in the 1938 London publication *Social Service in India: An Introduction to some Social and Economic Problems of the Indian People*, Figure 5.1).⁴ But a second, more exotic, geography was that of the tropical landscapes of India within which European health was presumed to be more at risk.⁵ This environmentalist paradigm was, of course, an ancient one, but its emphasis on *contamination* endured in the fecund tropical environment of India.⁶ Colonial medicine was, therefore, long obsessed with medical topography—the mapping of diseased environments. The transmission of disease could be through direct contact, through rotting or infected matter, or through aerial miasmas or 'mal-arias' (bad air), while the tropical climate was thought to weaken the body.⁷



Figure 5.1
Spaces of medical modernity in colonial India.

The government of India proved resilient to *contagion* theory until the 1890s, even as international sanitary conferences and cholera outbreaks along pilgrim routes in India presented evidence to support Koch's bacillus theory.⁸ Yet this eventual transition did not mean a significant and immediate shift in the types of interventionist spaces created through state medicine. Environmentalist understandings of pathogenic environments fueled demands for sanitary reform that were contrary to governmental financial preferences and the *laissez-faire* non-interventionism of the mid-to-late nineteenth century.⁹ Outbreaks of disease in the imperial port of Bombay necessitated, however, major infrastructural sanitary improvements that had a major impact on its urban morphology, and on the approach to urban landscaping in India more broadly.¹⁰ Such interventions targeted environmental conditions that made the spread of contagion more likely and, as such, carried forward the geographical imagination of the environmentalist paradigm, and also reinforced imperial claims to mastery over space (see Figure 5.2 for a typical contrast between disordered Indian towns and the glistening urbanism of colonial modernity).¹¹

Prostitution policies provide a famous example of this approach to space and disease. While 'venereal diseases' had never been associated with miasmas, their genital origins being all too evident, they were closely associated with contagion. This was a metaphorical connection, drawing upon the Augustinian depiction of the prostitute as the sewer that cleansed humanity. But it was also a practical one; the Contagious Diseases Acts (1864–69 in Britain, 1868 in India) had allowed for the registration, inspection, and, if infected, compulsory incarceration of prostitutes.¹² The Indian act was repealed in 1888, which left colonial authorities scrambling for a way of safeguarding their military cantonments from venereal disease.¹³ Only in the twentieth century would a broader concern with the Indian population lead to a more thoroughgoing policy regarding prostitution and urban health.¹⁴

The evolution of such geographical imaginations, and their inherent power relations, have been theorized by David Armstrong as "public health spaces."¹⁵ The environmentalist, or miasmatic, model associated disease with particular places and led to quarantine and the eradication of the threatening elements of the environment. This medical measure can be associated with the 'sovereign power' to appropriate territory, and to use violence and force to re-order space.¹⁶ The second model, of contagion, focused on flows between the body and the environment, and led to the establishment of *cordons sanitaire* between 'pure' and 'impure' people and places. This can be associated with a disciplinary



Figure 5.2
Contrasting urban forms in colonial India.

model of power that placed 'abnormal' (unhealthy, threatening) people or places under surveillance so as to monitor and reform infected people and places; a model of power based itself on the medieval European plague town.¹⁷ In her work on colonial Singapore, Brenda Yeoh has shown that "[t]hrough the interplay of strategies and counter-strategies, negotiation over the control of sanitary aspects of the urban environment played a key role in describing the relationship of power between ruler and the ruled."¹⁸ In attempting to lower the mortality rates of Chinese and Malay inhabitants of the island, disciplinary tactics of categorization, inspection, and surveillance were adopted, to limited effect. The impossibility of producing a self-disciplining "native subject," due to the limited funds of the municipal government and the radically different medical episteme of the local population, led to a shift in tactics:

The municipal 'inspecting gaze' had shifted from overseeing the daily practices of the Asian population carried out in specific spaces (such as the house, street, market, or public place) to controlling the dimensions, arrangements, and legibility of particular spaces (such as the house, the building block, and ultimately, the city as a whole) in order to influence the practices of those who inhabited or used such spaces.¹⁹

This shift in emphasis to the practices, not just the movement or health, of individuals is the key change here, and marks the deeper influence of contagion theory on public health spaces. This final model was termed that of "hygiene" by Armstrong and marks a concern with the interlinkages between personal and public health, as mediated by personal conduct. The association of the health of the individual body and that of the body politic is a keystone of "biopolitics," and the concern with the "conduct of conduct" was central to Foucault's interest in liberal governmentalities.²⁰ This shift does not, however, make hygiene any less geographical. The emphasis on the personal brought the home into the purview of health officials, and led to a broader conceived "dream of hygienic containment" that came to dominate "the extensive culture of hygiene which we know as public health."²¹ Contagion and hygiene are, therefore, not separate concepts or practices; instead, hygiene marked a distinct development in twentieth-century thinking regarding how to address the threat of contagion. But how would hygienist discourses play out in colonial arenas, which were marked by a neglect of individual care for colonial populations perceived as, at best, religious or ethnic communities or, at worst, an undifferentiated category of 'the native'?²²

This question has been most directly addressed by Alison Bashford's groundbreaking *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*.²³ Bashford showed that the boundaries, borders, enclosures, and interventions associated with hygiene and public health were also spatial tactics deployed by colonialism, nationalism, and racial administration: "All these spaces—these therapeutic, carceral, preventative, racial and eugenic geographies—produced identities of inclusion and exclusion, of belonging and citizenship, and of alienness."²⁴ Yet in the twentieth century, such policies had to apprehend an emerging emphasis, even in the colonies, on health and welfare and, later, citizenship, in which hygiene was not just a public health responsibility of the state, but also a duty of each individual. This marked, for Bashford, a clearly new stage of biopolitics, the administration of the life of a population through encouraging new conduct, but also through collecting new statistical information about a population. As Deana Heath has put it: "Hygiene connected the governance of the self to larger governmental projects and thus became a means of imagining and embodying the strength and purity of the individual, community, nation, and empire."²⁵ Yet she also acknowledges that imperial projects to manage the flow of polluting material (whether of the mind or body) around the empire often came into conflict with colonial models of hygiene that took on national, and unique, inflections. There were colonial logics at play that *depended* upon undermining the self-governing capacities of Indians so as to justify colonialism, to refute anti-colonial nationalist claims for *swaraj* (self-rule), and to further obfuscate the fact that so much Indian ill health was created by the conditions of colonial modernity (the overcrowded town fostering tuberculosis and venereal disease, or the newly cultivated paddy field conducive to malarial mosquitoes). David Arnold's recent work has demonstrated how beriberi (a condition caused by deficiency of vitamin B1 [thiamine] related to an over-dependency on polished rice) exposed the precarious vulnerability of laborers' bodies.²⁶ The cure, vitamin injections or tablets as well as changed diet, suggests a nutritional governmentality outside the scope of the growing body of work on colonial biopolitics.²⁷

Warwick Anderson's work, for instance, on American colonialism in the Philippines, examined the abstract depiction of American laboratory and public health spaces and bodies in relation to Filipino embodiment and impure spaces.²⁸ As against programs of immunization, which made war on a diseased population, hygiene marked a biopolitical engagement with individual health, though modified to take into account presumed native capacities.²⁹ Similarly,

Laura Briggs has examined American policy in Puerto Rico, showing how the 'difference' of the latter was reproduced through women's bodies and sexuality.³⁰ Inspired by British anti-contagious diseases legislation, a series of moral panics were mobilized to stoke fears over syphilis and the threat it posed to the American navy, women and children, and to Puerto Rican claims to U.S. citizenship and status.

Sarah Hodges has most directly addressed late colonial biopolitics in India, through her work on birth control and the related debates linking health and governance.³¹ Vitally, she stressed that such debates should go beyond the boundaries of the state, as governmentality studies have insisted, taking in social action and knowledge production regarding food or housing. Hodges also contrasts 'top-down' immunization with 'bottom-up' projects aimed at improving health in general through behavioral changes. Yet the latter were filtered through Indian 'difference' by the 'strange beast' of colonial welfare:

Succinctly, in the colonial Indian context, there existed neither institutions nor the desire to gather the kind of totalizing knowledge about the Indian subject population, nor was there either the political will to engineer large-scale transformations in the overall health profiles of the population.³²

Through such a lens, Hodges' interest in sex and sexuality is less concerned with the micromanaging studied by Ann Stoler and others.³³ Rather, "[i]n the 'welfarisation' of colonial sexuality, sex remains significant but less in terms of the precise acts and parties involved and more in terms of how sex was mobilized to connect individual practices to a broader social body."³⁴ This was exactly how prostitution came to be re-envisioned through the lens of hygiene, not as a perversion, or even as an urban nuisance, but as a risk to the population and, as explicitly rendered, the race. The demand that Indian women, both prostitutes and wives, be treated and cared for was part of a welfare push from Indian representatives that clashed with attempts to hem back the colonial state and reduce expenditure. This led to increasingly outward-looking Indian scientific elites, who looked to bodies like the League of Nations for inspiration in their project to "decolonize international health."³⁵ Understanding the development of contagion theory and its influence on planning and governmental policy, therefore, demands an appreciation of diachronic historical change and legacies in specific places, as well as a synchronic appreciation of imperial and internationalist networks. The rest of this chapter will attempt to convey some of this complexity through a summary of the evolution of public health in Delhi as explored through debates about urban living in general, and venereal

disease in particular. Second, an examination of the work of the British Social Hygiene Council will give an insight into some of the internationalist influences on sexual regulation in interwar India.

Delhi: Municipality, Province, and Capital

After the uprising of 1857, Delhi was apportioned to the Punjab Province but was administered by its own chief and deputy commissioners. In 1863, a Municipal Committee was established, consisting of the deputy commissioner, three Europeans, and seven nominated Indians.³⁶ The municipality immediately set about a series of infrastructural improvements to create a healthier environment in the city. These included road repairs; drain and sewer clearance; the creation of public latrines; the removal of encroachments on public lands; the removal deposits of offal and filth at Ajmeri and Turkman gates; the opening of a dispensary in Sadar Bazar by a hakim for those classes who “. . . though poor, have no faith in English medicines;”³⁷ the removal of a cremation ground to a site “less objectionable” on sanitary grounds; and the closure of burial places near the (European) Civil Station, while all burials within 500 yards of the city walls were banned. An elaborate system was also put in place to track the population of the city, both for planning purposes and to better calculate rates of mortality. The registration of births was initiated through binding mullah sweepers to report within 24 hours all births and deaths, for which they were paid a fee, but would forfeit their job should they fail. For the first four months, all relatives were ordered also to register births, to check if the system was working. While it is highly unlikely, given the Municipal Committee’s track record of urban governance, that this system worked, it gives a sense of the intent, at least, to understand Delhi as both a place of disease and of a variable population. Such efforts continued over the following decades: wells were cleaned and the city ditch cleared; the slaughterhouse was moved outside of the city walls, as were other “offensive trades”; the city and suburbs were divided into *ilaka* subdivisions and were regularly inspected for problems, mainly with conservancy. However, as with Singapore, it was found that about a quarter of the municipal budget was being spent on the police.

In 1878, a sanitation subcommittee was established in line with broader trends across larger municipalities throughout India. Many of the ideas informing the logic of the committee were crystallized in a publication by the vice-chairman of the Calcutta municipal board, Reginald Craufuird Sterndale’s

1881 *Municipal Work in India; or, Hints on Sanitation, General Conservancy and Improvements in Municipalities, Towns and Villages*.³⁸ In fitting with contemporary Orientalist discourses, Sterndale praised India's ancient texts for embodying the principles of municipal rule, yet claimed these traditions had become extinct, until revived by the "liberal minded administrator, the late Sir Cecil Beadon, during his Lieutenant-Governorship of Bengal."³⁹ One of the key duties of a municipal committee was to apply sanitary science so as to remove the sanitary evils associated with departing from the rules of nature. While later hygiene science would emphasize the importance of domestic and personal health, the sanitary mindset condemned the Indian for prioritizing such concerns and failing in infrastructural science and public health: "Ancient, however, as sanitary laws may be, they do not seem to have been in vogue at any time among the Hindus; and this, although the Hindu shastras teem with laws for the purification of the body and household cleansing."⁴⁰ Such laws were said to be appropriate for scattered dwellings but not for cramped urban living. Liberal sanitary laws and regulations were said to be based on three simple principles:

1. That the protection of health and comfort was as much a right as that of security of life and property;
2. That property brings duties and responsibilities as well as rights and privileges; no one should cause offence to their neighbors;
3. That individual interest must be subordinate to the interests of the community at large.

. . . in the present day it is necessary to base our sanitary regulations upon a [more] utilitarian foundation,—viz., that the individual must be content to sacrifice a small part of the possible profit or pleasure he might derive from the unrestricted use of his own estate for the general benefit or enjoyment of the community.⁴¹

What this makes exceptionally clear is that sanitary science was not just part of, but at the vanguard of, liberal governmentalities that sought to craft out, in the name of contagion theory, possessive individualistic subjectivities through the manipulation of material space. This immediately, however, called forth the inherent tension in liberalism: give people individual rights and they can use them to block inconvenient projects for the common good. Liberal governmentalities relied upon these checks on state power, hemming back government to allow the free functioning of society and population. Sterndale also noted that certain writers on economics (J. S. Mill) oppose state interference on such matters. He could, however, fall back on the notion of

difference; what he was detailing was not just *liberal* governance, but a particularly *colonial* governmentality:

It must, however, be admitted that the State must protect those who are incapable of discriminating between what is and what is not necessarily for their own good; and this is undeniably the condition of the mass of our Indian town populations. In regard to questions of sanitation and hygiene, they are as ignorant and helpless as children or imbeciles, and it is, therefore, the undoubted duty of the State, and under it the local authorities, to do for them what they cannot do for themselves, and what selfish and short-sighted landlords will not do for them . . .⁴²

Despite the mention of hygiene, it was the environment of the poor land-laboring classes that was thought to represent the most urgent threat: quarters where soil and atmosphere reached the lowest depths of contamination; where subsoil and surface water went undrained; where houses were surrounded in filth and the air was burdened with “noisome emanations.” This was the rallying call to municipalities across India and, while Delhi motioned towards suitable action, the money, motivation, or capacity was not supplied until a crisis and an opportunity presented themselves in the early twentieth century.

The crisis was that of the plague. Although anti-plague measures were most vigorous, and have been most commented upon, in Bombay, due to its status as an international port, the disease was actually more lethal in the Punjab area of north India from which Delhi had been carved.⁴³ In 1901–03, a few cases of the disease were reported each year but did not spread, while 1903–04 saw 11 cases, still way fewer than the 91 cases of cholera that year.⁴⁴ In 1904–05, however, the plague ‘became indigenous,’ with 637 deaths reported, although the actual number of dead would have been much higher. The worst suffering was in the poorer and cramped suburbs of Paharganj and Sabzi Mandi outside the city walls. Affected premises were disinfected free of cost and pamphlets on prevention were translated and distributed. There were over 300 deaths the following year and 35 in 1906–07, but the plague returned in 1910–11. Few agreed to be inoculated and the only measures available were to move people out of quarters where the disease was worst.

While these measures reflected the relatively modest health apparatus of the city at this time, a dramatic event in the winter of 1911 radically changed Delhi’s prospects. At the imperial durbar in the city in December of that year, King George V announced that the capital of India would be moved from Calcutta to Delhi itself, and that a new capital would be constructed near the

old city. Delhi would become a centrally administered province, and strenuous efforts were made by the municipality to match its new status as part of the capital region. A health officer was appointed in August 1912, charged with addressing the sanitary and general health of the city. As such, future epidemics were treated with much more intensity. In 1917–18, an outbreak of influenza was met with a rash of measures, including notices in English, Urdu, and Hindi throughout the city; lectures in houses and *bastis*; disinfection of affected houses; “Elphinstone Picture Palace” slides detailing preventative measures deployed; disinfection of trams and notices distributed against spitting; closure of schools and colleges; reductions in the gathering of people in cinemas and theaters; and the establishment of 18 street dispensaries and eight traveling dispensaries. The shift towards an emphasis on hygiene, conduct, and education is clear here, but these were largely curative measures. With regard to the plague, Delhi now worked towards a preventative science. In 1923, the central government of India’s public health commissioner reported with satisfaction on Delhi’s anti-plague measures. The city’s geographical position and railway connections left it open to the plague, prevalent in neighboring provinces, from all sides. An outbreak in 1922–23 had killed 1,510 in the city and 1,185 in the district, but the significance of these statistics was made very clear:

The proximity of the Imperial City with its 30000 inhabitants and of the winter headquarters of the Government of India made it imperative that the progress of the disease be watched closely; consequently the possibilities of a large ‘carry over’ of infection to the winter of 1923–24 had early engaged the attention of the Department of Education, Health and Lands and the local Public Health authorities.⁴⁵

A similar emphasis on the capital can be detected in anti-malarial policy. In 1912 when the site for the new city was being determined, the “relative malariousness” of different sites was mapped. From this, recommendations emerged for combating malaria in the city: a canal to the north of the old city was to be cut off and filled up; the *darbar* area to the north of the city was to have flood protection measures installed; canals within the old city were to be treated; and, within New Delhi, proper storm channels were to be installed and open pits to be filled in. However, a report from 1927 showed that the only thorough action to have been taken was that in the new city. An examination showed that there were still seriously high levels of malaria in Delhi, so Rs50,000 were provided for action in 1930–31. A further report in 1936 acknowledged the lack

of progress, but questioned whether efforts should focus on Delhi province, or just New Delhi. Were action to occur more broadly, it was, again, clear why:

The following notes are based on the principle that anti-mosquito measures, if applied to New Delhi municipal area alone, will not in all probability suffice to control malaria in the New City, since the existence of an infected population in its immediate vicinity may from time to time induce outbreaks of malaria within the city itself and, moreover malaria carrying mosquitoes may under favourable meteorological conditions be brought into New Delhi from outside areas, however perfect the control of breeding may be within the New Delhi municipal area itself.⁴⁶

Both of these reports represent the extent to which Old Delhi's administration was over-determined, and explicitly controlled, by the central government in New Delhi, and how the racial geographies of Delhi's health geographies were thereby implicitly fortified. The annual reports by Delhi's medical officer charted the growing frustration with this organization, as Delhi became more and more congested due to people flocking to the capital city.⁴⁷ One of the most passionate campaigners for health reform in Delhi was Dr K. S. Sethna, whose 1929 report charted and statistically tabulated the disease and congestion that wracked the old city. But the problem was as much one of medical approach as material conditions. He argued, "[a]lthough the Science of Hygiene has developed at a rapid rate, the public outlook on Health as opposed to Disease has not altogether changed."⁴⁸ Sethna wrote that the old idea of medicine was to cure. While still correct, hygiene also aimed to prevent illness, which was still under-appreciated in India. Health should accompany human progress and comfort:

We have talked about a 'Sanitary Conscience' but we have not yet evolved what I should call a 'Health Atmosphere'. More and more responsibility is taken from the shoulders of the general public and placed on the Health Department, so much so that instead of acting and thinking for themselves many people require someone to act for them.

While there was ever-increasing demand for municipal sanitation, this need would lessen were people to act hygienically (to stop throwing refuse in the street, to use drains, to keep food clean, to notify rather than hide infectious diseases). In sum, the need was for popular *cooperation*.

Alas, nine years later, Sethna found that his calls had gone unheard. In the 1938 report, he argued that, while the cost of preserving public health was great, it was less than the cost of disease; reducing the cost of the latter depended

on prevention. He chastized the public for not showing themselves worthy of such investment, for not knowing what they, as *citizens*, paid for: pre-natal clinics were not used; diseases not notified; women not given access to venereal disease clinics by their husbands. Sethna had gone so far as to hire health propaganda staff who went through the city singing “health songs” composed by his department. His object was that all members of public health departments be “disciples of hygiene” to guide the public. The benefits of this distanced yet intense conduct would be to remove the paralyzing fear of sickness. In his retiring address, after 24 years of public service in Delhi, Sethna pleaded:

The evolution of public health work from the prevention of contagious diseases to the prevention of all diseases and further from the negative prevention of diseases to the positive appeal for health has resulted in a very complex health organisation . . . [but] Health, like Charity, begins at home.⁴⁹

The home was thus returned to, but as the site for a revolution in health, not for Sterndale’s sparing approval of Hindu domestic economy. Yet the domestic sphere, and individual conduct, was a realm that remained beyond the scope, or even desire, of the colonial government, whether the New Delhi authorities, the Delhi administration, or the Municipal Committee. While tuberculosis wracked the city, there were no effective measures to re-house slum dwellers, and the city extensions were taken up by the expanding middle classes.⁵⁰ Similarly, while rates of venereal diseases remained high in the city, thorough-going legislation was not passed until the 1940s.⁵¹ This was, in part, the result of campaigning by Meliscent Shephard, the representative in India of the Association of Moral and Social Hygiene (AMSH).⁵² But Shephard’s objections to prostitution were dominated by the concerns of *moral* hygiene, namely, the unequal moral standard and the exploitation of women to satisfy the desires of men. *Social* hygiene focused more intently on science and medicine and proffered an alternative set of techniques for challenging the most infamous of the ‘contagious diseases.’

The British Social Hygiene Council

. . . contagion is always about contact. Thus through most of the nineteenth century ‘contagious diseases’ meant sexually transmitted diseases—transmission through the closest and most problematised contact of all.⁵³

If hygiene marked a new peak in the intensity of biopolitics, it also marked a novel intervention in the governing of the sexual self.⁵⁴ Hygiene emerged as a key technology at several intersections of the domains of sexual conduct and population regulation.⁵⁵ These included the literature of sexology; Havelock Ellis, for instance, wrote both the six-volume *Studies in the Psychology of Sex* and *The Task of Social Hygiene*.⁵⁶ Another was that of public feminism, in which venereal diseases and the role of men and women were discussed, while a final intersection was that of eugenics and public health. Bashford has shown that segregation was *not* simply the spatial response of a contagionist mindset; “health detention,” or the lock hospital model, continued into the twentieth century in Queensland, for example.⁵⁷ But she also shows how, in the pages of the British Social Hygiene Council’s (BSHC) journal, *Health and Empire*, the “threat of compulsion” was highlighted and the need for voluntary healthcare for infected women prioritized, while also stressing the *imperial* threat that venereal disease posed.

As suggested above, while moral hygiene drew attention to the immorality of prostitution, social hygiene focused on the threat posed by prostitution to the health of the population. In the United States, it was closely associated with sexual regulation, prostitution, and the control of venereal diseases, while in the United Kingdom, at its broadest, social hygiene targeted birth control, family policy, nutrition, industrial efficiency, social policy, and ‘mental hygiene,’ especially of the poor.⁵⁸ The BSHC title was adopted in 1924 by the National Council for Combating Venereal Diseases (NCCVD), which had been formed to implement the recommendations of the 1916 report of the Royal Commission on Venereal Diseases.⁵⁹ It focused on extending free treatment for venereal diseases into the civilian population and was funded by the state. Yet its earliest reports show that it appreciated that venereal disease was as much an imperial and international concern. It contemplated not just the risk of venereal disease to the United Kingdom, but also of, for instance, diseased African soldiers returning home after the war. As such, a traveling commission of medical advisors was funded in 1920 to visit the East (Gibraltar, Ceylon, Colombo, Malta, Singapore, and Hong Kong) and the West (the Bahamas, St Vincent, Bermuda, Jamaica, Barbados, British Guiana, and Antigua). The BSHC had also established a branch and dispensary at Bombay in 1918, which registered 1,296 people in 1919–20, many of whom were prostitutes.⁶⁰ This branch was taken over by municipal authorities by 1923.⁶¹

Unlike the AMSH, which focused on working with and through local organizations, the BSHC wanted organizations throughout the empire affiliated to it and working upon the same general lines.⁶² Perhaps with this in mind, the government of India declined the offer of a visit from the traveling commission, although a separate commission was accepted between November 1926 and March 1927.⁶³ The states of Bihar and Orissa pronounced themselves opposed to the commission and refused to cooperate, while the “political atmosphere” in Bengal made a visit impossible.⁶⁴ During the tour, Mrs Neville-Rolfe had an interview with the public health commissioner, who admitted that the large towns needed action, but that the government was wary of raising the question of prostitution. The resulting BSHC report on India highlighted what it viewed to be high levels of gonorrhea and syphilis, a low level of outpatient care, and a near total absence of full-course treatment for venereal diseases. This was attributed to a lack of medical staff, premises, and equipment. The BSHC made recommendations along three lines that bridged the medical concern with the “contagiousness” of venereal diseases with the hygiene concerns about their “socialness.” Rejecting any notion of compulsory segregation or detention, the medical recommendations were all regarding in- or outpatient care and the establishment of teaching hospitals, child welfare centers, and drug distribution centers. In terms of social action, there was need for a campaign of “public enlightenment” that would explain the relationship between commercial prostitution, venereal disease, and the “racial effects” of syphilis and gonorrhea. The council also recommended cinema censorship, the penalization of commercial prostitution, and that hostels be provided for those undergoing treatment.

This bringing together of the social and the medical was in line with the BSHC’s imperial vision. In 1924, the NCCVD published a report on its first Imperial Social Hygiene Congress, in which it declared its intention to tackle the social problems that lay behind sexually transmitted diseases.⁶⁵ The Congress was addressed by the Minister of Health, who stressed the need for collective action to challenge “Free Trade in disease,” and by the president of the NCCVD, who outlined the “racial” threat posed by gonorrhea and syphilis. It was left to the late colonial secretary, L. S. Amery, to address the outside world, which he did through tackling “Imperial Questions,” which were divided geographically. For dominions, the question was one of “securing the concentration of an intelligent and outspoken public interest on the great social and health problems connected with these diseases,” preventing them, and curing them quickly.⁶⁶ For colonies and dependencies, however, the

question was different, due to Britain's greater responsibility. This was no longer simply the responsibility for establishing law and order or eradicating those "grosser superstitions" through a form of negative trusteeship, as embodied in Sterndale's approach to Indians' (non-)capacities for self-governance. Rather, public opinion was acknowledging that Britain's trusteeship "has its very positive aspects and obligations, and that we are concerned not merely in keeping the peace but in endeavouring to make the very most out of the populations for whom we have assumed responsibility."⁶⁷ While Britain had come to terms with the need for political education in its colonies and dependencies, it had under-emphasized training in "social life, health, and moral conduct." This struggle by the colonial state to acknowledge a form of governance that was positive, that went beyond the violent adjudication of peace to making the most out of populations through training in social life, health, and moral conduct, is by now a familiar one through the literature on late colonial biopolitics. It was a governmentality taken up by Dr Sethna in Delhi, it was acknowledged by the government of India as it extended its protective measures against venereal disease beyond the cantonment, and it was at the very heart of the AMSH's imperial campaign.

However, as the paper presented at the congress by Dame Rachel Crowdy on "international positions" regarding prostitution and trafficking suggested, the imperial perspective was already being augmented by alternative, yet also transnational, opinion.⁶⁸ This was acknowledged in 1934, when the British Social Hygiene Council published its first Empire Social Hygiene Year-Book. As with the Imperial Social Hygiene congresses, serving and retired members of the Indian Civil Service were well represented. The foreword was provided by Sir Basil Blackett, who had worked in India between 1922 and 1928 as a financial expert and served as the occasional president of the BSHC on his return.⁶⁹ He began by recalling the heady influence of imperialism in the "nineties," at both its best (Kipling) and worst (violent jingoism). However, in 1934, he admitted that catchwords such as "King and Country" or "white man's burden" were now deemed superior or insulting to fellow citizens in India or Africa. Echoing Amery's comments 10 years previously, he suggested the task of empire had changed from that of supplying law and order to demonstrating the best of Western civilization. In the post-war period of doubt, people were said to have turned to the "international" and not the "imperial." The League of Nations would come to have a significant impact upon prostitution policy in India, and it was thoroughly penetrated by hygienist literature. It was, however, swayed

from its earlier social hygienist emphasis on science and the policing of prostitution to a moral hygienist interest in the traffic in women and children.⁷⁰ While the League contributed greatly to the global campaign against epidemics and for social medicine,⁷¹ its effects in India were, as with nineteenth-century debates on municipal liberalism, mediated by racial difference and geographies of sovereignty and colonial governmentality.⁷²

These internationalist conduits of hygiene thought were, therefore, as subject to colonial difference as former stages of contagionist thinking, and also had their effects on the planning of urban space. In terms of social hygiene, the major effect was to encourage the abolition of tolerated brothel zones and to outlaw soliciting in the street.⁷³ The laws that enforced these hygienist concerns displayed the historical and translocal influences that this chapter has tried to demonstrate; a contagionist but individualist concern with infection, as well as a newly internationalist concern both with imperial race and the potential of a postcolonial scientific modernity.